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The Honorable Dorcas R. Hardy
Chair, Policy Committee
White House Conference on Aging
4350 East-West Highway, 3rd Floor
Bethesda, MD 20814

Dear Ms. Hardy:

Thank you for the opportunity to review the resolutions in the White House Conference on Aging (WHCoA) Preliminary Report. I commend you, Dr. Scott Nystrom, and everyone who spent countless hours planning for, and executing, the 2005 WHCoA. Before I comment on the resolutions, I want to raise some concerns – concerns I have, and ones also raised by the delegation representing Washington State at this conference, held only once every ten years.

First and foremost, our country is on the precipice of experiencing the greatest number of Americans turning 60 in our nation's history. Nearly 1,200 conference attendees traveled, many from great distances, because they recognize the critical importance of setting the roadmap for aging in our nation. They were very disappointed that there was no meeting with the President. Not since the first WHCoA a half-century ago has a President *not* attended. I understand President Bush instead met with a small, hand-picked group of seniors in northern Virginia.

I am also disappointed that the WHCoA did not reinstate the 10-percent rule for bringing resolutions to the floor. This limited floor recommendations to only those proposals already submitted prior to the meeting. While I heard that discussion around the pre-filed proposals was good, I believe we also lost many fresh, valuable ideas that the impressive and distinguished group of conference delegates brought with them, which could and should have been part of the effort.

Thirdly, I find it unfortunate that materials created by the delegates during the Implementation Strategy Sessions are not being distributed. In your November 22, 2005 cover letter to the 2005 WHCoA Resolutions Workbook, you speak specifically to the fact that the "implementation strategies are essential." Furthermore, while recognizing that the resolutions are vital in establishing *what* priorities the nation should address, the implementation sessions, as you write, "should suggest *how* the resolutions might be put into action." Given that so much time was spent by the delegates creating implementation strategies, I think it only natural that these strategies be released to the states so that we might further benefit from the work of the WHCoA.

Washington State's WHCoA delegates are all experts in the field of aging, with varied and diverse backgrounds. Their input enhances several areas of high priority and activity for Washington State that I wish to highlight after examining the preliminary report. All are tied to the top ten resolutions that WHCoA delegates adopted.

Many of the resolutions are quite complex, having both intergovernmental and fiscal implications. Washington State has historically placed strong emphasis on developing research-based, fiscally responsible and innovative strategies to better serve its aging and long-term care (LTC) populations. Our strategies will continue to evolve in order to keep pace with demographic changes and the continuing desire for increased consumer choice. We hope that WHCoA efforts support our own.

**Reauthorization of the Older Americans Act**

Like all WHCoA delegates, including Washington State's, I echo resounding support for **Resolution 17** to *Reauthorize the Older Americans Act (OAA) within the First Six Months Following The 2005 White House Conference on Aging.* With 1,061 votes, the interest in reauthorization is without question. Because OAA expired in 2005, the importance of quick Congressional action is also apparent and recognized.

I also applaud the Administration on Aging's proposal for reauthorizing, "Choices for Independence," a demonstration project that builds on the mission and success of the OAA and aims to strengthen and modernize its role in promoting consumer choice, control, and independence in long-term care. In addition to reauthorizing OAA, Congress must fund it appropriately, rather than the flat funding it has received for too many years now.

With 29 federally recognized Tribes in Washington State, OAA reauthorization must also consider the unique status of American Indians and fully recognize the federal Trust Responsibility to this population. As Congress continues its work on reauthorization, I encourage members to consider integrating delivery systems that allow Area Agencies on Aging (AAAs) to assist Tribal councils and Title VI programs in planning for the aging "baby boomer" population also occurring on reservations.

**Long-Term Care Task Force on Financing and Chronic Care Management**

Greater flexibility for states and new innovative partnerships are important steps to developing systems of long-term care. Delegates recognized this in adopting **Resolution 30**, to *Develop a Coordinated, Comprehensive Long-Term Care Strategy by Supporting Public and Private Sector Initiatives that Address Financing, Choice, Quality, Service Delivery, and the Paid and Unpaid Workers.*

In Washington State, we are already working on developing such strategies. During the 2005 legislative session, our Legislature approved my proposal to create a joint legislative and executive Long-Term Care Task Force on Financing and Chronic Care Management to address the future of long-term care in Washington State. The Task Force will review and make recommendations about public and private financing, and recommend chronic care management and disability prevention interventions to reduce health care and LTC costs to both individuals and the state. These interventions will include having access to health professionals and caregivers who are well-trained in issues affecting older people.

I ask that the federal government, including the Veteran's Administration (VA) and Indian Health Services, partner with us, and with the private sector, to explore innovative funding sources to provide the necessary infrastructure and service options, without burdening Washington and other states with additional federal mandates. The VA will be particularly instrumental to these efforts, given that 50 percent of men over the age of 75 are veterans.

**Medicare and the Medicare Modernization Act**

Delegates to the WHCoA were absolutely correct in adopting **Resolution 51** to *Strengthen and Improve the Medicare Program.* Like all states, Washington experienced a crisis when, on January 1, 2006, 96,000 of our most vulnerable citizens were forced into the new Medicare Part D program created by the Medicare Modernization Act (MMA). This dual-eligible population, eligible for both Medicaid and Medicare, has serious mental and physical health problems, including HIV/AIDS, organ transplantations, cardiovascular disease, and cancer. This population also encompasses those with developmental disabilities, Alzheimer's and other dementia, severe physical disabilities, and chronic disease co-morbidity.

The dual-eligible population is now required to pay a co-pay of anywhere from $1 to $5 for every prescription they need – this, in striking contrast to when they were on Medicaid and had no co-pay. A co-pay of $1 to $5 may not sound like a lot to some, but many of these citizens live on $579 or less per month. In Washington State, the average number of prescriptions taken by a dual-eligible beneficiary is seven, with many taking fifteen or more. The resulting co-pay of $35 to $75 per month is a huge barrier, preventing many from accessing life-saving, life-stabilizing medications they need. Many of our dual eligible citizens are entirely dependent on their medications, unable to go a day without them. Yet the new federal requirement for co-pays means this is exactly what is happening.

While there are a multitude of MMA transition issues that must be dealt with, the issue of co-pays continues to be the greatest concern. In January and February, I worked directly with Health and Human Services (HHS) Secretary Michael Leavitt on a mechanism to help our dual-eligible citizens meet the new co-pay requirement. Secretary Leavitt committed $14 million to Washington State, "savings" from our clawback, which will pay these co-pays for one year. Clearly, we need a permanent solution. These people cannot afford co-pays and the state should not be picking up the tab.

It is important to note, too, that American Indian Elders find cost sharing counter to the Federal Trust responsibility and are resistant to utilizing the program. Furthermore, it is surprising that the new MAA law contains an institutional bias requiring that dual-eligible beneficiaries who receive long-term care in home and community based settings pay co-pays while those in institutions do not. This bias needs to be corrected. Not only does it add one more burden to the lives of individuals who are chronically ill and/or vulnerable, it is also counterintuitive to the President's New Freedom Act and national initiatives intended to slow the growth of long-term care costs.

I believe the MAA is a fundamentally flawed federal program and I will continue working with HHS and Washington's congressional delegation to find permanent solutions. We, as a nation, find ourselves in the throes of the Part D confusion. Our congressional delegation continues to fight to make the program one that meets the needs of the people it serves. Senators Cantwell and Murray, especially, are dogged in their fight to lessen the negative impact of the transition and make the new program easier on all Medicare beneficiaries, and especially for those who are dually eligible. I will continue to work with the entire Washington delegation to repeal the co-payment requirement for dual eligibles, as well as change any other section of the new Medicare drug program that is a barrier to Washingtonians receiving the health care they need and deserve.

**Home and Community Based Services**

In line with **Resolution 42**, to *Promote Innovative Models of Non-Institutional Long-Term Care,* and **Resolution 71**, to *Improve State and Local Based Integrated Delivery Systems to Meet 21st Century Needs of Seniors,* I take great pride in progress Washington State has made to provide our disabled citizens with options for possible community living. Washingtonians continue to prefer consumer-directed home and community-based care, whenever feasible.

For over two decades, building the capacity for quality home and community-based care and slowing the growth of long-term care costs have guided our efforts to provide long-term care services in Washington State. Our Department of Social and Health Services (DSHS) Aging and Disability Services Administration (ADSA) has expanded community supports and now approximately 70 percent of our aging and long-term care population receive in-home and community-based services. Capacity-building continues, with emphasis on serving special populations that include American Indians, ethnic and cultural minorities, those with limited English-speaking proficiency, many who are geographically isolated, those with traumatic brain injuries, and citizens struggling with Alzheimer's disease or other dementia processes.

We continue to explore service delivery options to help slow LTC expenditures. These include expanding delegation of nursing activities for community residential and in-home consumers, implementing self-directed care, and, more recently, participating in a grant to pilot a cash and counseling project, as well as funding chronic care management projects. Planning for affordable senior housing in livable, senior-friendly communities where individuals can more successfully "age in place" is also essential.

Currently, the Medicaid statute mandates that beneficiaries who are nursing home eligible be treated in nursing homes. However, all 50 states operate under waivers designed to create some measure of flexibility on long-term care, and 31 states include a form of community-based personal attendant care in their programs. I believe Congress and the Administration should take legislative and/or regulatory steps to provide states with the flexibility to offer elderly and disabled beneficiaries a more balanced choice between nursing home and community-based services. Flexibility is also needed to develop better options for workable Tribal LTC programs that consider the Federal Trust responsibility. I would also support streamlining to the necessary waivers, but encourage retaining provisions that give states the ability to set budget limitations and determine budget neutrality.

**Expansion of Aging and Disability Resource Centers**

I am extremely pleased that last year Washington State was approved for a three-year Aging & Disabilities Resource Center (ADRC) grant, another tool related to the goals of **Resolution 71**. The grant funding will assist DSHS-ADSA to continue developing consumer-based LTC services enabling individuals with disabilities or long-term illnesses to live in integrated community settings, choose their service providers, and obtain quality care. This grant also matches the goals set forth for our state's Long-Term Care Task Force on Financing and Chronic Care Management, including building a social consciousness about long-term care, and the options available, by facilitating individual planning around costs and services.

We see this grant as an opportunity to build on our very successful aging information and assistance/referral (aging I&A/R) programs administered by the AAAs. These programs have recently demonstrated the depth of their professionalism and abilities by responding to the need for one-on-one education and assistance with Medicare enrollment for both general and dual-eligible Medicare beneficiaries in Washington State. However, because of funding limitations, AAAs were only able to serve persons 60 years of age and older and had to delay other obligations.

By the end of the third year, the pilot ADRC Washington State received will serve those of all ages who have physical and/or cognitive disabilities, including those with limited English proficiency. We will also have developed a strategic plan for statewide expansion of ADRC's, which is integral to ensuring quality and choice in our state's long-term care system. I intend to work with the National Governors Association to advocate for federal support of the ADRC concept, which is one I highly value.

**Geriatric Education Centers**

**Resolution 41**, to *Support Geriatric Education and Training for All Healthcare Professionals, Paraprofessionals, Health Profession Students, and Direct Care Workers*, is also of the utmost importance. Over the course of the next 20 years, the over-65 population in Washington State will go from roughly 11percent of the population to 20 percent. In that same period of time, the ratio of workers able to care for this population (generally those between the ages of 20 and 54)

will decline, from 4.5:1 to 2.5:1. This stark contrast is distressing and I commend the WHCoA delegates for recognizing the workforce need to support our elders.

Given the importance of geriatric education and training to me, my state, and the WHCoA delegates, I am astounded that the Fiscal Year 2006 budget adopted by Congress eliminates funding for the Geriatric Education Center (GEC). Here in the Northwest, we have been fortunate to have the Northwest Geriatric Education Center (NWGEC) at the University of Washington. The NWGEC has been improving the health and quality of life of the Northwest's older adults since 1985 though its leadership in providing continuing education to geriatric healthcare and social service practitioners.

Also, recently, NWGEC facilitated the states of Alaska and Montana in obtaining their own GECs and is working with Wyoming to do the same. To not have the support of Congress or the Administration for something as vital as geriatric education and training is counterintuitive, and I implore Congress to right a wrong and restore Geriatric Education Center funding.

As Washington State's WHCoA delegates continue to share their work from the Conference with me and my administration, as well as with our Washington State Council on Aging, I again ask for the release of all WHCoA delegate Implementation Strategy Session products. We have done well in determining what we must do in the coming years, the challenge now is, as you say, the how.

Thank you, again, for the fine work of the WHCoA. I look forward to seeing changes in federal legislation and/or regulatory steps that will complement the exceptional efforts already underway here in Washington, and that will support every state's efforts to meet the challenges and opportunities presented by our increasing, aging and elderly population.

Sincerely,

Christine Gregoire

Christine O. Gregoire
Governor

cc: Robin Arnold-Williams, Secretary, DSHS
Mary Selecky, Secretary, DOH
Steve Hill, Administrator, Health Care Authority
Doug Porter, Assistant Secretary, Health & Recovery Administration, DSHS
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